State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	David M Meyers	
Doing Business As	Cornerstones, LLC	
Name of Parent Corporation	/	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	1090 Main St Branford, CT 06405	
Applicant type (e.g., profit/non-profit)	Profit	
Contact person, including title or position	David M. Meyers, LCSW Executive Director	
Contact person's street mailing address	P.O. Box 567 Branford, CT 06405	
Contact person's phone #, fax # and e-mail address	203-260-0647 fax: 203-315-1557 e: DavidMmeyers@yahoo.com	

Please call with Questions -

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:
Cornerstones, LLC

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☒ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

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☐ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):
1090 Main St, Branford, CT 06405.

d. List all the municipalities this project is intended to serve:
Branford, Guilford, Madison, New Haven, East Haven,

e. Estimated starting date for the project: 9/1/05

f. Type of project: 18 **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
None				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ 0

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$ 0
Medical Equipment (Purchase)	0
Imaging Equipment (Purchase)	0
Non-Medical Equipment (Purchase)	0
Sales Tax	0
Delivery & Installation	0
Total Capital Expenditure	$ 0
Fair Market Value of Leased Equipment	0
Total Capital Cost	$ 0

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
None				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): None Needed.

SECTION IV. PROJECT DESCRIPTION See attached.

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

SECTION IV. PROJECT DESCRIPTION

1. *Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.*

Services provided by Cornerstones is outpatient mental health counseling. We provide group, individual, family psychotherapy. Currently no other licenses are held with DPH

2. *What types of services are being proposed and what DPH licensure categories will be sought, if applicable?*

Out patient mental health services are provided and we are seeking DPH licensure- Mental health psychiatric Outpatient clinic

3. *Who is the current population served and who is the target population to be served?*

Current and Target population are shoreline children and families that are in need of mental health outpatient psychotherapy.

4. *Identify any unmet need and how this project will fulfill that need.*

There is currently a lack of mental health clinics and providers on the shoreline of Connecticut and this clinic hopes to alleviate the backlog that many clinics currently are experiencing.

5. *Are there any similar existing service providers in the proposed geographic area?*

There are community mental health centers in each town. New Haven houses Clifford Beers and Yale out patient clinics.

6. *What is the effect of this project on the health care delivery system in the State of Connecticut?*

Increases availability of mental health services to children and families who are in need of Psychiatric treatment and counseling

7. *Who will be responsible for providing the service?*

The clinical staff at Cornerstones provides direct client care. Currently the staff consists of Social workers, and Psychiatry services

8. *Who are the payers of this service?*

The clinic accepts clients with many insurance plans as well as self pay clientele.

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

N/A.